STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155319	A. BUILDING 00 B. WING	03/25/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERS OF CLINTON THE	375 S 11TH ST CLINTON, IN47842

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00086100. Complaint IN00086100 unsubstantiated due to lack of evidence. Survey dates: March 21-25, 2011 Facility number: 000212 Provider number: 155319 AIM number: 100285040 Survey team: Teresa Buske RN /TC Laura Brashear RN Mary Weyls RN Census bed type: SNF/NF: 86 Total: 86 Census payor type: Medicare: 14 Medicaid: 59 Other: 13 Total: 86 Sample: 18 Supplemental sample: 5 These deficiencies also reflect state findings in accordance with 410 IAC 16.2.	F0000	**Preparation and/or execution of this plan of correction in general, or this corrective action in particular, foes not constitute an admission or agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and federal laws.**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	Quality review completed 3-31-11 Cathy Emswiller RN			

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F0156 SS=C	Based on observation and interview, the facility failed to prominently display in the facility written information about how to apply for and use Medicare and Medicaid benefits and how to receive refunds for previous payments covered by such benefits. This deficient practice had the potential to affect 86 of 86 residents who currently resided in the facility. Finding includes: During environmental tour on 3/25/11 which began at 12:25 p.m. with the Maintenance Supervisor posted information about how to apply for and use Medicare and Medicaid benefits was not observed. The Administrator was	F0156	**F 156 – Notice of rights, rules, services, charges.** It is the intent to prominently display in the facility, written information about how to apply for and use Medicare and Medicaid benefits and how to receive refunds for previous payments covered by such payments. 1. **CORRECTIVE ACTION:** a. A written posting of information about how to apply for and use Medicare and Medicaid benefits and how to receive refunds for previous payments covered by such benefits is posted in the front lobby. 2. **OTHERS IDENTIFIED:** No others were identified. 3. **SYSTEMS IN PLACE:** Information will remain posted; be reviewed annually in January; and updated as necessary, along with other legally required postings. 4. **MONITORING:** ADM/Designee will review all posted information annually in January; and update as necessary. All/any changes of posted information will be reviewed in the quarterly QA Committee meeting with the Medical Director to ensure on-going compliance. 5. **DATE COMPLETE:** This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 3/26/11.	03/26/2011

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	interviewed at that time and provided a binder containing Medicare and Medicaid information located in a holder on the wall of the front lounge area with the Survey results. A posting of where the information was located was lacking. 3.1-4(l)(1)			

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F0282 SS=D	Based on observation, interview, and record review, the facility failed to follow physician orders of therapeutic diets i.e. appropriate calorie count and/or form for 2 of 15 residents observed receiving meals in a sample of 18. [Resident #81 and Resident #33] Findings include: 1. On 3/22/11 at 12:15 p.m., Resident #81 was observed to eat lunch in the dining room. The resident was observed to receive rice, chop suey, wheat bread and margarine, 8 ounces of milk, and apple dessert. Interview of the dietary manager on 3/22/11 at 12:40 p.m. indicated the resident received a regular menued	F0282	**F 282 – Services by qualified person per care plan.** It is the intent of the facility to follow physician orders of therapeutic diets. 1. **CORRECTIVE ACTION:** a. Resident #81's diet card was updated and revised to reflect current physician order of CCD NAS. b. Resident # 33's diet card was updated to reflect a Mechanical Soft Diet. 2. **OTHERS IDENTIFIED:** a. Dietary Manager performed 100% audit of all resident's physician orders and diet tray cards. There were no other residents identified. 3. **SYSTEMS IN PLACE:** a. New diet orders are placed on the Dietary Communication Form and sent to the dietary department. The dietary department then updates the resident tray card. All new diet orders will be reviewed in the daily stand-up meeting by the IDT team. Staff were in-serviced on 3/28/11,3/29/11, and also 04/06/11 to include proper procedure of the Dietary Communication Form for accuracy of the tray card. 4. **MONITORING:** a. The Dietary Manager/Designee will monitor weekly to ensure all physician diet orders correspond with the resident tray care. New orders	04/06/2011

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	portion of rice and chop suey, and apple cobbler dessert. The dietary manager indicated the facility did not have a diet for 1500 calorie diabetic diet, 3 gram sodium diet. The dietary manager indicated the facility had tried to eliminate restrictive diets. Review of the therapeutic diets for 3/22/11 at 12 p.m. did not indicate a menu for 1500 calorie diabetic diet 3 gram sodium diet. Review of the resident's dietary card on 3/22/11 at 12 p.m. indicated 1500 calorie controlled carbohydrate diet. Review of the clinical record of Resident #81 on 3/22/11 at 2:40 p.m. indicated a current physician's order dated 11/4/10		will be reviewed during daily stand-up meeting to ensure accuracy of the diet tray card. b. The IDT will review/audit quarterly during care plan review for compliance. c. ADM/Designee will review all audits in monthly QA meeting; and in the quarterly QA Committee meeting with the Medical Director to ensure on-going compliance. 5. **DATE COMPLETE:** This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 4/06/11.	

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	that included but was not limited to 1500 calorie 3 gram sodium diabetic diet, and Levemir (insulin analog) 10 units subcutaneously daily may increase by 2 units every week until fasting glucose less than 120. A physician progress note dated 11/4/10 indicated increased glucose levels between 177-324, HgbAIC (blood glucose test) - 8.6 (normal 4.1-6.1), and diabetes mellitus - new onset, plan- long acting insulin and diet modification. A dietary note from Registered Dietician dated 12/6/10 indicated "...Diet is 1500 calorie 3 gram sodium diet but resident makes own choices. snacks often, non-compliant w[with] any restrictions. No [changes] needed at this time."			

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Review of March 2011 medication administration record as of 3/23/11 indicated the resident was receiving Levemir (Insulin) 46 units every morning subcutaneously.

Review of the current plan of care the problem of resident has potential for clinically unavoidable breakdown dated 11/2/09 revised 2/23/11 with approaches that included but not limited to diet as per MD order.

A physician's order was noted dated 3/22/11 at 2 p.m. of resident to receive controlled carbohydrate no added salt diet.

2. On 3/22/11 at 12:10 p.m., Resident # 33 was observed to be eating in her room. The

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	resident was observed to receive regular pork chop. The resident was observed to be unable to chew the pork chop. Interview of the resident on 3/22/11 at 12:10 p.m. indicated she was unable to eat the pork chop and that it was "tough." Review of the clinical record of Resident #33 on 3/24/11 at 3:25 p.m. indicated a current physician's order dated 12/28/10 of mechanical soft diet with ground meat with gravy. The most recent Minimum Data Set (MDS) assessment dated 3/23/11 identified the resident with no cognitive impairment. Review of the resident's diet card on 3/25/11 at 10:55 a.m. indicated diet as "Fortified			

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	Foods." Interview of the Dietary Manager on 3/25/11 at 10:55 a.m. indicated the resident was on the mechanical soft diet list in the kitchen and that the dietary card did not reflect the physician diet order of mechanical soft with ground meat with gravy. The dietary manager indicated the resident should not have received the regular pork chop. 3.1-35(g)(2)			

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F0322 SS=D	Based on observation, interview and record review, the facility failed to check gastrostomy tube placement for 1 of 1 resident with a gastrostomy tube in a sample of 15 prior to water flushes and medication administration. [Resident #82] Finding includes: On 3/24/11 at 12:20 p.m., RN #6 was observed to administer water flushes and medication through a gastrostomy tube to Resident #82. After uncapping the tube, the nurse placed a syringe into the tube, and poured water into the syringe. The nurse indicated she heard air when she placed the syringe although did not aspirate or auscultate the tube for placement. The nurse	F0322	**F 322 – Nasogastric Treatment/Services – restore eating skills.** It is the intent of the facility to ensure gastrostomy tube placement is checked prior to water flushes and medications for residents with gastrostomy tubes. 1. **CORRECTIVE ACTION:** a. An in-service was held 4/11/11 and 4/12/11 for all licensed staff reviewing proper checking for placement of a gastrostomy tube prior to flushes and medication administration. 2. **OTHERS IDENTIFIED:** No other residents were identified. 3. **SYSTEMS IN PLACE:** a. DON/Designee will perform random audits 1x daily, 5x weekly, including all shifts, to monitor for appropriate checking of g-tube placement by licensed nurses prior to flushes and administration of medications via gastrostomy tubes. 4. **MONITORING:** a. The Administrator/Designee will review all audits as completed. b. All audits will be reviewed by the IDT at the monthly QA meeting; and quarterly QA meeting with Medical Director. This will be an on-going QA process until 100% compliance has been obtained. 5. **DATE COMPLETE:** This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 4/15/11.	04/15/2011

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continued with the medication, flush, and recapped the tube. During interview at that time, the nurse indicated the resident had a bolus feeding around 10:00 a.m. and received bolus feedings three times a day.

Review of the clinical record of Resident #82 on 3/22/11 at 2 p.m. indicated the physician order on the March 2011 signed recap of flush gastrostomy tube with 250 cc [cubic centimeters] of water three times daily and flush the gastrostomy tube with 60 cc of water before and after feeding. A physician order dated 1/20/11 of " 2 cal HN" bolus one can three times daily.

A facility policy titled "Tube Feeding," dated 1/07, provided by the DON on 3/25/11 at 9:40

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	a.m. included, but was not limited to, "Procedure: ...5. Check placement prior to any feeding, medication or flush administration for G-tubes, J-tubes and N/G tubes. Documentation of placement checks is included on Tube Feed Administration Record for each shift.: 3.1-44(a)(2)			

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F0323 SS=D	Based on observation and record review, the facility failed to ensure a safe environment in that 2 of 2 residents in a sample of 18 were observed not to be transferred with mechanical lifts in accordance with manufacturers' directions in a sample of 18. [Resident #25, Resident #41] Findings include: 1. On 3/23/11 at 12 p.m., Resident #25 was observed to be transferred from the bed to the Broda chair utilizing the "Arjo" mechanical lift by CNAs #3 and #4. The lift base was observed to be in closed position when the resident was lifted from the bed surface. The CNAs raised the resident 24 inches off of the bed surface.	F0323	**F 323 – Free of Accident/Hazards/Supervision** It is the intent of the facility to ensure residents are transferred with mechanical lifts in accordance with manufacturers' directions. 1. **CORRECTIVE ACTION:** CNA's were observed for proper lifting techniques with the use of mechanical lifts. Any staff that demonstrated deficient practices in protocol were redirected to acceptable practice and required to give a return demonstration to demonstrate competency in skills and techniques as it relates to safety and manufacturers' directions. 2. **OTHERS IDENTIFIED:** There were no others identified. 3. **SYSTEMS IN PLACE:** The Director of Nurses/Designee shall perform random audits, to include a return demonstration, of proper use of mechanical lifts 3 times weekly until full compliance is maintained. Thereafter, random routine monitoring will be performed as a part of daily rounds. 4. **MONITORING:** a. The Director of Nurses/Designee will review all audits as completed in the daily QA meeting with the IDT. b. ADM/Designee will review all audits at the monthly QA meeting and at the Quarterly QA meeting with the Medical Director. 5. **DATE COMPLETE:** This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of	04/15/2011

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	The resident remained in the high position during the entire lift. The resident's buttocks was at the height of CNAs' waists. 2. On 3/23/11 at 2:10 p.m., Resident #41 was observed to be transferred from the wheelchair to the bed utilizing the "Arjo" mechanical lift by CNAs #3 and #4. The rear wheels were locked prior to lifting the resident from the wheelchair seat. The CNAs unlocked the rear wheels prior to moving the resident in lift to the bed surface. The resident was 6 inches off the surface off the bed. Review of the Manufacturer's directions for the "Arjo" mechanical lift on 3/24/11 at 9:05 a.m. indicated "Do not lock the brakes or block the		compliance is 4/15/11.	

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	wheels when lifting patient. The wheels must be FREE to roll to allow the lifter to center itself beneath patient....To reduce the hazard of tipping over, spread adjustable base lifters to their widest position before lifting anyone...If transporting over a short distance, ensure that patient is facing attendant and keep patient as low as possible so that her feet rest on the base of the lifter straddling the mast. Lower center of gravity reduces the risk of tipping over...." 3.1-45(a)(2)			

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F0367 SS=D	Based on observation, interview, and record review, the facility failed to ensure each resident received the therapeutic diet prescribed by physician i.e. appropriate calorie count and/or form for 2 of 15 residents observed receiving meals in a sample of 18. [Resident #81 and Resident #33] Findings include: 1. On 3/22/11 at 12:15 p.m., Resident #81 was observed to eat lunch in the dining room. The resident was observed to receive rice, chop suey, wheat bread and margarine, 8 ounces of milk, and apple dessert. Interview of the dietary manager on 3/22/11 at 12:40 p.m. indicated the resident	F0367	F 367 – Therapeutic Diet prescribed by physician. It is the intent of the facility to ensure each resident receives therapeutic diets as prescribed by their physician. 1. CORRECTIVE ACTION: a. Resident #81's diet card was updated and revised to reflect current physician order. 2. OTHERS IDENTIFIED: a. Dietary Manager performed 100% audit of all resident's physician orders and diet tray cards. There were no other residents identified. 3. SYSTEMS IN PLACE: a. All new diet orders will be reviewed in the daily stand-up meeting by the IDT team. b. Staff were in-serviced on 3/28/11, 3/29/11 and 04/06/11 to include proper procedure of the Dietary Communication Form for accuracy of the tray card. 4. MONITORING: a. The Dietary Manager/Designee will monitor/audit weekly to ensure all physician diet orders correspond with the resident tray care. b. IDT Committee will review/audit each resident quarterly with care plans for compliance.	04/15/2011

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	received a regular menued portion of rice and chop suey, and apple cobbler dessert. The dietary manager indicated the facility did not have a diet for 1500 calorie diabetic diet, 3 gram sodium diet. The dietary manager indicated the facility had tried to eliminate restrictive diets. Review of the therapeutic diets for 3/22/11 at 12 p.m. did not indicate a menu for 1500 calorie diabetic diet 3 gram sodium diet. Review of the resident's dietary card on 3/22/11 at 12 p.m. indicated 1500 calorie controlled carbohydrate diet. Review of the clinical record of Resident #81 on 3/22/11 at 2:40 p.m. indicated a current		c. ADM/Designee will review all audits in the monthly QA Committee meeting with the IDT; and in the quarterly QA meeting with the Medical Director to ensure on-going compliance. 5. DATE COMPLETE: This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 04/15/11.	

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	155319	A. BUILDING 00 B. WING	03/25/2011

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	physician's order dated 11/4/10 that included but was not limited to 1500 calorie 3 gram sodium diabetic diet, and Levemir (insulin analog) 10 units subcutaneously daily may increase by 2 units every week until fasting glucose less than 120. A physician progress note dated 11/4/10 indicated increased glucose levels between 177-324, HgbAIC (blood glucose test) - 8.6 (normal 4.1-6.1), and diabetes mellitus - new onset, plan- long acting insulin and diet modification. A dietary note from Registered Dietician dated 12/6/10 indicated "...Diet is 1500 calorie 3 gram sodium diet but resident makes own choices. snacks often, non-compliant w[with] any restrictions. No			

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[changes] needed at this time."

Review of March 2011 medication administration record as of 3/23/11 indicated the resident was receiving Levemir (Insulin) 46 units every morning subcutaneously.

Review of the current plan of care the problem of resident has potential for clinically unavoidable breakdown dated 11/2/09 revised 2/23/11 with approaches that included but not limited to diet as per MD order.

A physician's order was noted dated 3/22/11 at 2 p.m. of resident to receive controlled carbohydrate no added salt diet.

2. On 3/22/11 at 12:10 p.m., Resident # 33 was observed to

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	be eating in her room. The resident was observed to receive regular pork chop. The resident was observed to be unable to chew the pork chop. Interview of the resident on 3/22/11 at 12:10 p.m. indicated she was unable to eat the pork chop and that it was "tough." Review of the clinical record of Resident #33 on 3/24/11 at 3:25 p.m. indicated a current physician's order dated 12/28/10 of mechanical soft diet with ground meat with gravy. The most recent Minimum Data Set (MDS) assessment dated 3/23/11 identified the resident with no cognitive impairment. Review of the resident's diet card on 3/25/11 at 10:55 a.m.			

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	indicated diet as "Fortified Foods." Interview of the dietary manager on 3/25/11 at 10:55 a.m. indicated the resident was on the mechanical soft diet list in the kitchen and that the dietary card did not reflect the physician diet order of mechanical soft with ground meat with gravy. The dietary manager indicated the resident should not have received the regular pork chop. 3.1-21(b)			

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F0368 SS=E	Based on interview and record review, the facility failed to offer snacks at bedtime daily for 10 of 11 residents present in group meeting . [Resident # 27, Resident # 31, Resident # 21, Resident #23, Resident #14, Resident #10, Resident # 84, Resident # 36, Resident # 74, Resident # 15] Findings include: During group interview on 3/22/11 which began at 9:45 a.m., 10 of 11 residents [Resident # 27, Resident # 31, Resident # 21, Resident #23, Resident #14, Resident #10, Resident # 84, Resident # 36, Resident # 74, Resident # 15] indicated snacks were not offered at bedtime. During interview of the FSS (Food Service Supervision) on 3/24/11 at 7:50 a.m., the FSS indicated the dietary department sent out therapeutic snacks for specific residents and stocked the refrigerators on the nursing units for residents not receiving a therapeutic snack. The FSS indicated nursing was to provide the bedtime snacks. During interview of RN #19, on 3/26/11 at 3:30 p.m., the RN indicated she worked the evening shift. The RN indicated therapeutic snacks were passed by the	F0368	**F 368 – Frequency of meals/snacks at bedtime.** It is the intent of the facility to offer snacks at bedtime daily for all residents.. 1. **CORRECTIVE ACTION:** a. The nursing department, in the evening, are to record snack acceptance or refusal by each resident. 2. **OTHERS IDENTIFIED:** All residents could be affected. 3. **SYSTEMS IN PLACE:** a. A member of the nursing department will offer a bedtime snack to each resident every evening, and record their acceptance and/or refusal of a bedtime snack. 4. **MONITORING:** a. The Activity Director/Designee will audit intake and/or refusal of bedtime snacks weekly. This will be an on-going QA process. b. Bedtime Snacks will be maintained on the Resident Council agenda for review monthly. This will be an on-going QA process. c. ADM/Designee will review all audits in the monthly QA Committee meeting and will review in the quarterly QA meeting with the Medical Director to ensure on-going compliance.	04/15/2011

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	nurses. The RN indicated for residents not receiving therapeutic snacks there were plenty of snacks in the refrigerator and if somebody woke up and requested a snack they provided the snack. During interview of LPN #17, on 3/26/11 at 3:45 p.m., the LPN indicated she worked the evening shift. The LPN indicated if residents were sitting up around the nurses station, evening snacks were provided. During interview of CNA #18, on 3/26/11 at 3:20 p.m., the CNA indicated the nurses take care of the snacks. Review of the facility's current policy and procedure titled "Snacks at Bedtime" dated 2004 on 3/25/11 at 11:20 a.m. indicated "...Bedtime snacks of nourishing quality will be provided for residents and plan to meet special dietary modification...Procedure: Bedtime snacks are served by nursing department prior to sleep in residents' location of choice..." 3.1-21(e)		5. **DATE COMPLETE:** This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 4/15/11.	

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F0371 SS=F	Based on observation, interview and record interview, the facility failed to ensure 1. Dietary practices were implemented to prevent the potential for food borne illnesses for 1 of 1 residents (#81) in a sample of 18 and 5 of 5 residents (#31, #47, #55, #74, #80) in a supplemental sample of 5, who were identified as consuming unpasteurized soft fried eggs periodically for the breakfast meal in the main dining room, and 2. The hot water temperature for the rinse cycle on the dishwashing machine reached the proper temperature to sanitize utensils and dishes. This had the potential to affect 85 of the 86 residents residing in the facility who received meals prepared in 1 of 1 facility kitchen. Findings include: 1. On 3/23/11 at 10 a.m., the MDS (minimum data set) coordinator person indicated, residents that consume their breakfast meals in the dining room, receive a choice of entrees including soft fried eggs. The coordinator indicated only the resident that consumed breakfast in the dining room had a choice of how their eggs would be cook. During interview of the FSS (food service	F0371	**F 371 – Food Procure, store/prepared/serve – sanitary.** It is the intent of this facility to perform dietary practices to prevent the potential for food borne illness; by purchasing pasteurized eggs; and by ensuring the hot water temperature for the rinse cycle on the dishwashing machine reaches proper temperatures to sanitize utensils and dishes. 1. **CORRECTIVE ACTION:** a. All unpasturized eggs were discarded 3/23/11. A new shipment of pasturized eggs were delivered to the facility on 3/24/11. b. The bad heating element in the booster heater of the dishwashing machine was replaced. All three elements were replaced on 3/21/11. All soiled utensils and dishes were washed after the repair was made. 2. **OTHERS IDENTIFIED:** There were no negative outcomes for the residents identified. 3. **SYSTEMS IN PLACE:** a. All eggs purchased for the facility for consumption will be pasturized eggs. b. All dietary staff were in-serviced on 3/21/11 and 04/06/11 regarding proper documentation of temperature logs, the importance of maintaining proper temperatures for sanitization of utensils and dishes, policies and	04/15/2011

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	supervisor) on 3/23/11 at 1 p.m., the FSS was unsure if the facility utilized pasteurized eggs. Review of the facility menus, for the week of March 20th through 26th 2011, provided by the FSS on 3/22/11 at 12 noon, the menus indicated for the breakfast meal "Egg of choice". On 3/23/11 at 1:10 p.m., with the FSS, thirty cartons containing a dozen of eggs in each carton were observed. The cartons of eggs had no indication that the eggs were pasteurized. During interview of the Administrator on 3/23/11 at 1:30 p.m., the Administrator was unaware the facility was not utilizing pasteurized eggs. The Administrator was unsure if the residents had been provided information concerning the potential harm of consuming soft fried unpasteurized eggs. On 3/23/11 at 2:40 p.m., the FSS provided a list of names of residents that at times requested and received soft fried eggs. The following resident names were on the list, Resident #'s 31, 47, 55, 74, 81, 80. During interview of resident #55 on 3/23/11 at 3:15 p.m., the resident indicated that she will request soft fried		procedures, including manual washing of utensils and dishes for proper sanitation. 4. **MONITORING:** a. Administrator will monitor weekly invoices to ensure all eggs purchased are pasturized. This will be an on-going QA process. b. Dietary Manager will monitor Dishwasher Temperature Logs daily to ensure proper temperatures are maintained. Temperatures that are non-compliant will be immediately addressed by Maintenance department. c. Dietary Manager/Designee will review temperatures in the daily QA meeting with IDT and quarterly in QA meeting with the Medical Director to ensure on-going compliance. 5. **DATE COMPLETE:** This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 4/15/11.	

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	eggs at times. The resident indicated she likes her egg yolk runny, and if its not, she will sent it back. During interview of Dietary Cook #5 on 3/24/11 at 8:05 a.m., the cook indicated that she would cook a plate of soft eggs, and when requested would give the soft eggs to the resident's requesting. The cook indicated that she did not check the temperature of the eggs prior to serving, but at times would warm them up in the microwave. During interview of the Administrator on 3/24/11 at 10:10 a.m., the Administrator indicated eggs received after January 2011, were not pasteurized. 2. During Kitchen food service observation on 3/21/11 which began at 11:45 a.m., with the FSS , the external thermometer on the dishwasher did not register during the rinse cycle. The FSS ran a thermometer through the dishwasher and the thermometer registered 150 degrees Fahrenheit. Documentation on the dishwashing machine indicated the wash cycle needed to reach 150 degrees Fahrenheit and the rinse cycle 180 degrees Fahrenheit.			

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	During interview of the FSS on 3/21/11 at 12 noon, the FSS indicated the the dishwashing machine was a Hot Water Temperature machine. The FSS indicated staff check the external thermometer in the AM and in the PM. On 3/21/11 at 1 p.m., the Administrator provided a form dated March 2011, titled "Equipment Temperature Log" "Dishmachine" The A.M. temperatures from March 1st to the 21st indicated the dishwasher temperatures ranged between 380 degrees Fahrenheit to 400 degrees Fahrenheit. The evening temperatures for March 1st to the 20th indicated the temperatures ranged between 136 degrees to 140 degrees Fahrenheit. During interview of dietary staff person #20, on 3/21/12 at 11:45 a.m., the staff person indicated, she is responsible for running the dishmachine. Staff person indicated she had checked the external dial on the dishmachine that morning. On 3/21/11 at 12:00 p.m., the Maintenance Supervisor checked the dishmachine and indicated the rinse cycle was not hot enough. During interview of the Maintenance Supervisor on, 3/22/12 at 10:55 a.m., the Maintenance supervisor indicated the			

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	dishwasher had a element that was not working. The Maintenance supervisor indicated he had changed the element and the dishwasher was not reaching the adequate temperature to sanitize the dishes. 3.1-21(i)(3)			

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F0386 SS=D	Based on record review and interview, the facility failed to ensure the resident's physician signed orders and/or wrote progress notes at each visit for 2 of 15 resident records reviewed in a sample of 18. [Resident #51 , Resident #63] Findings include: 1. Resident # 51's clinical record was reviewed on 3/22/11 at 11 a.m. An admission date was noted of 9/4/2009. The most recent physician's rewrite order, was noted, signed November 2010. Physician progress notes since 11/2010 were lacking. A nurses note, dated 2/9/11, indicated the resident was seen by a physician. 2. Resident #63's clinical record was reviewed on 3/23/11 at 1 p.m. The most recent physician's rewrite order, was noted, dated 11/20/10. During interview with the Medical Records Staff member, on 3/23/11 at 2 p.m., the medical records staff member indicated resident #'s 51 and 63 were seen	F0386	**F 386 – Physician visits – review care/notes/orders.** It is the intent of the facility to ensure the resident's physician signs orders and/or writes progress notes for each visit. 1. **CORRECTIVE ACTION:** a. In regards to Resident # 51 and Resident # 63, the physician came to the facility and provided her documentation on 3/23/11. 2. **OTHERS IDENTIFIED:** There were no others identified. 3. **SYSTEMS IN PLACE:** a. Medical records will perform monthly audits to ensure all residents have orders signed in a timely manner; and progress notes signed by their physicians correlating with their visits.. b. If physicians are non-compliant a courtesy call will be made. If non-compliance continues, the facility medical director will provide the necessary services. 4. **MONITORING:** a. Medical records will review/monitor with monthly audits. Any deficiencies will be reported in the daily QA meeting as they occur. b. QA Committee will review the findings of the audits monthly and at the quarterly QA meeting with the Medical Director..Non-Compliance will be directed to the Medical Director for correction. 5. **DATE COMPLETE:** This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our	04/15/2011

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	by physicians but the physicians orders and/or physician progress notes since November 2010 were lacking. 3.1-22(c)(1) 3.1-22(c)(2)		date of compliance is 04/15/11.	

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F0441 SS=E	Based on observation and record review, the facility failed to ensure hand hygiene was maintained to prevent contamination by : 1) 2 of 7 licensed nurses observed providing care i.e. administering medications/accuchecks and/or nasogastric tube care for 4 of 7 residents observed receiving care by licensed nurses in a sample of 18 and 2) 1 of 6 CNAs observed providing incontinence care to 1 of 5 residents observed incontinent in a sample of 18. [Resident #80, Resident #82, Resident # 28, Resident #36, Resident #4] [RN #6, LPN #1, CNA #12] Findings include: 1. On 3/22/11 at 9 a.m., LPN # 1 was observed to administer eye drops to Resident # 28. The nurse was observed not to wear gloves to administer the eye drops. The LPN was observed to directly touch the resident's skin around the resident's eye when administering the drops. Without washing her hands, LPN #1 was observed to go the nursing station and obtain a resident's chart. The LPN then was observed to pick up phone to use. Review of the facility's current policy and procedure titled "Eye Drop and Eye Ointment Administration" dated 1/1/05 on	F0441	**F 441 – Infection Controll, prevent spread, linens** It is the intent for this facility to ensure hand hygiene is maintained to prevent contamination in providing care during medication administration, accuchecks and/or nasogastric tube care and all personal care. 1. **CORRECTIVE ACTION:** All nursing staff were re-educated on infection control, prevention of spread of infection, hand washing, and glove usage in providing care, i.e. medication pass, accuchecks, gastric tubes, and peri care. 2. **OTHERS IDENTIFIED:** No others were identified. 3. **SYSTEMS IN PLACE:** a. All nursing staff were in-serviced, 03/29/11and 03/30/11, on infection control, prevention of spread of infection, hand washing and glove usage. b. Licensed nurses were reviewed/audited per proficiencies: to perform proper proper handwashing and use of alcohol gel; usage of and proper procedure for donning and removal of gloves, to prevent the spread of infection. 4. **MONITORING:** a. The DON/Designee will audit handwashing/glove usage for at least 5 staff members daily, to include all shifts for the next 30 days; then five staff members weekly, to include all shifts for the next 30 days; then five staff members monthly, to include all shifts for the next 30 days. Any	04/15/2011

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WATERS OF CLINTON THE	375 S 11TH ST CLINTON, IN47842

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	3/25/11 at 11:35 a.m. indicated "...Procedure....3. Wash hands, apply gloves, and assure good lighting..." 2. On 3/22/11 at 11:48 a.m., LPN #1 with gloves on was observed to administer insulin subcutaneously to Resident #36. Without changing the contaminated gloves, LPN #1 was observed to open the door to the resident's room, exit and then remove the gloves. The nurse then washed hands.		non-compliance will be immediately corrected. The facility will contine with five staff members being audited per month, including all shifts, as an on-going QA process. b. ADM/Designee will review all audits as completed in the daily stand-up meeting. c. ADM/Designee will review all audits during the monthly QA meeting and the quarterly QA meeting with the Medical Director for on-going compliance. 5. **DATE COMPLETE:** This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 4/15/11.	